ABSTRACT

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A STUDY OF THE EFFECTIVENESS OF PSYCHOEDUCATIONAL GROUP INTERVENTION IN TREATING ALCOHOLISM

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The purpose of this study was to examine the effectiveness of psychoeducational group techniques in reducing an individuals' level of alcohol intake. It was hypothesized that when one is more educated about alcoholism, and how the addictive behavior began, their level of alcohol intake will decrease. To test this hypothesis, the researcher monitored changes in the alcohol involvement of a middle-aged African American woman engaged in psychoeducational group treatment. The researcher monitored these changes by administering the subject a standardized questionnaire developed by Hudson, before intervention, during intervention, and after completion of intervention. The results of the study show that by involvement in psycho-educational groups and cognitive therapy, the subject was able to reduce her overall level of alcohol intake.

A STUDY OF THE EFFECTIVENESS OF PSYCHOEDUCATIONAL GROUP INTERVENTION IN TREATING ALCOHOLISM

A THESIS

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TABLE OF CONTENTS

PAGE

ACKNOWLEDGMENTS.....ii

LIST OF FIGURES.....v

CHAPTER

I. INTRODUCTION.....1

Significance of Study.....4

Purpose.....7

Research Question.....7

Summary.....7

Overview of the Following Chapters.....8

II. REVIEW OF LITERATURE.....9

Alcoholism Overview.....9

Etiology of Alcoholism.....11

Moral Model.....11

Sociocultural and Psychological Models.....11

Sociocultural.....12

Psychological.....13

Biological.....16

Multivariate Model.....17

Summary of Etiology of Alcoholism.....18

Consequences of Alcoholism.....19

Psychoeducational Group Intervention.....21

Theoretical Framework.....23

Summary of Proposed Study.....28

TABLE OF CONTENTS

(continued)

CHAPTER PAGE

Research Question....28

Treatment Hypothesis....29

III. METHODOLOGY....30

Research Design....30

Instrument....32

Setting....34

Treatment Hypothesis....35

Case Information....35

Intervention Strategy and Implementation....37

IV. PRESENTATION OF FINDINGS....41

V. CONCLUSIONS....48

Limitations of the Study....49

Recommendations for Future Studies....49

VI. IMPLICATIONS FOR SOCIAL WORK PRACTICE....51

APPENDICES....54

A. Client Consent Form....55

B. Index of Alcohol Involvement (IAI)....57

BIBLIOGRAPHY....59

LIST OF FIGURES

FIGURE PAGE

1. A Cognitive Model of Substance Abuse.....27
2. Patient's Alcohol Involvement in Baseline Phase.....42
3. Patient's Alcohol Involvement in Intervention Phase..44
4. Patient's Alcohol Involvement in Follow-up Phase.....45
5. Patient's Alcohol Involvement in Baseline, Intervention, and Follow-up Phases.....47

CHAPTER ONE

INTRODUCTION

One of the major health problems in the United States is the abuse of alcohol (Pattison and Kaufman, 1992). Alcoholism ranks as the third most prevalent health problem in this society. According to Pattison and Kaufman (1992), the problems associated with alcohol are not limited to the health problems of alcohol, but their alcoholism adversely affects many persons associated with the alcoholic (Pattison and Kaufman, 1992).

Beginning in the 1960's and 1970's, the United States began to focus on illegal drugs, such as marijuana and cocaine, and in the 1980's and 1990s, crack and heroin. According to Dilulio (1996), in "Broken Bottles: Alcohol, Disorder, and Crime," the United States has spent billions of dollars to wage a war on these illegal drugs as part of a broader effort to fight crime and community breakdown, specifically in the inner city. However, the particular focus on illegal drugs has kept the spotlight off a legal, more dangerous, psychoactive drug, alcohol (Dilulio, 1996).

Dilulio (1996) suggests that the United States tends not to focus on alcohol for many reasons. These include adult liquor sales, which are considered legal, the

assumption that most people drink in moderation, and the growing concern with drugs. However, the relationships between alcohol and problems such as health, family, social, vocational, and legal must not be ignored.

In 1990, there were a reported 100,000 deaths caused by alcoholism, specified as the third leading cause of death (McGinnis and Foege, 1993). The National Institute of Mental Health (1992), in a large epidemiological study, reported that the lifetime prevalence for alcoholism in the United States is 13.8 percent. One in seven people meet the criteria for alcohol abuse. According to the U.S. Department of Health and Human Services, one million Americans exhibit some symptoms of alcohol dependence (Wormer, 1995). The life span of the average alcoholic is about 12 years shorter than that of the average citizen (Rovner, 1990).

The regular consumption of large amounts of alcohol (defined as more than three drinks a day) is undesirable from the standpoint of health for almost all people (Friedman and Klatsky, 1993). Although there are fewer deaths from alcohol-related causes than from cancer or heart disease, alcohol related deaths tend to occur at much younger ages. Studies of suicide victims in the general population show that about 10 percent of alcoholics commit suicide and over 18 percent are found to have a high history

of suicide attempts. The increasing suicide rates among the young has also been linked to alcohol abuse (1993).

According to the National Institute Against Alcohol Abuse (NIAAA, 1993), heavy and chronic drinking can harm virtually every organ and system in the body. The NIAAA (1993) identifies it as the single most important cause of illness and death from liver disease (i.e., alcohol hepatitis, cirrhosis) and is associated with cardiovascular diseases, such as cardiomyopathy, hypertension, arrhythmias, and stroke. Alcohol use contributes to approximately 65% of all cases of pancreatitis. The use of alcohol depresses the immune system and results in a predisposition to infectious diseases, including respiratory infections, pneumonia, and tuberculosis. The risk for cancer increases with alcohol use, with an estimated 2-4% of all cancer cases thought to be caused either directly or indirectly by alcohol. The strongest links between alcohol and cancer involves cancers of the upper digestive tract, including the esophagus, the mouth, the pharynx, and the larynx.

The NIAAA (1993) further reported that alcohol use can lead to inadequate functioning of the testes and ovaries, resulting in hormonal deficiencies, sexual dysfunction, and infertility. Heavy drinking has also been found to be related to higher rates of early menopause and higher frequency of menstrual irregularities in women. Each year 4,000 to 12,000 babies are born with the physical signs and

intellectual disabilities associated with fetal alcohol-syndrome, and thousands more experience the somewhat lesser disabilities of fetal alcohol effects. The NIAAA (1993) further reported that an association has been established in both homosexual and heterosexual populations between alcohol use and behavior that increases the risk for contracting HIV and other sexually transmitted diseases.

The National Institute of Drug Use (1993) reported that alcohol abuse is associated with over half the deaths and major injuries suffered in automobile accidents each year, and with about 50 percent of all murders, 40 percent of all assaults, 35 percent or more of all rapes, and 30 percent of all suicides. They also report that one out of every three arrests in the United States is related to alcohol abuse.

Alcoholism cuts across race, age, gender, educational, occupational, and socioeconomic boundaries. Alcoholism is a major problem in the industry, in the professions, and in the military. It is also found among seemingly unlikely candidates, such as priests, airline pilots, politicians, surgeons, law enforcement agencies, and teenagers (Carson, et al., 1998). According to the authors, "the once popular image of the alcoholic as an unkept resident of skidrow is clearly inaccurate" (Carson, et al., 1998, p. 357).

Significance of Study

Alcoholism remains among the most serious problems of society today. Alcohol abuse has killed more people, sent

more victims to the hospital, caused more police arrests, broken up more marriages and homes, and cost industry more money than the abuse of heroin, amphetamines, barbiturates, and marijuana combined (Magura, 1994). Excessive drinking is a problem among all classes and ages, including adolescents, etc.

According to Magura (1994), little has changed in the treatment modalities in the last two decades. However, the perceived substance abuse crisis and the mixed effectiveness of current treatment are exerting pressures for change. The author emphasizes the current movement to develop intensive, comprehensive models for alcohol abuse treatment based on relapse prevention techniques, and cognitive-behavioral principles. Researchers have also suggested that evaluation and research be done on the effectiveness of current counseling practices and outpatient treatment models because, as it currently stands, little is known about the effectiveness of treatment approaches for alcoholism. According to McGrady and Irvine (1989), even the most widely known treatment approach, Alcoholics Anonymous (AA), lacks significant evidence supporting its effectiveness. The authors point out that concepts of evaluation and research for practice improvement receive relatively little attention in substance abuse treatment programs.

Social workers do not appear to be well represented in substance abuse treatment programs when considering the

problems of the client populations and the program functions that need to be performed. The NIAAA (1993) reports that in 1991 social workers constituted 8.5 percent of the direct staff of substance abuse treatment agencies.

Magura (1994) suggests that expanding the participation of social workers in substance abuse treatment programs would improve the effectiveness of this service area. The rationale for such expanded participation included: improvement in direct services to clients, evaluation and accountability of programs, research on practice issues, and development of new treatment modalities (Magura, 1994).

The Institute of Medicine (1990) further emphasizes the need for increased participation of social workers in this service area. They state that, "in the future, substance abuse treatment will emphasize the development of a broader range of programs and services to meet the range of clients' needs with a concurrent emphasis on matching clients to treatment" (Institute of Medicine, 1990, p. 36). According to Smyth (1995), in the Encyclopedia of Social Work, "social work has the potential to emerge as a key profession by responding to changes in the substance abuse field both in direct practice and practice research" (p. 2335). Social workers possess many of the necessary skills to make contributions to the substance abuse field. These include: generalist practice skills, assessment of the person in the

context of the environment, the individualization of intervention, and practice and programs evaluation skills.

Purpose

The purpose of this study is to examine the effectiveness of psychoeducational group techniques in reducing an individual's level of alcohol intake. According to Miller and Hester (1986), alcoholism evolves from deficient knowledge and when armed with correct knowledge, individuals will be less likely to use alcohol in an unhealthy fashion and to suffer the consequences. Despite the frequent use of psychoeducational groups as part of treatment, no study has rigorously evaluated their effectiveness (Smyth, 1995).

Research Question

Are psychoeducational groups effective in educating clients about alcoholism, and ultimately reducing their level of alcohol intake?

Summary

Alcoholism is an old, yet a new, story. Alcohol abuse has been a societal problem for many decades (Wormer, 1995). However, little has changed in treatment approaches and, as Wormer points out, there are a number of unresolved issues in the alcoholism field. Among these unresolved issues is the lack of evidence supporting the effectiveness or non-effectiveness of treatment approaches. Evaluation of

practice does not appear to be a concern in this service area. At the same time, the recovery rate for alcoholism is not high, which indicates a need for a better understanding of the disorder as well as researching various interventions to treat alcoholism.

Overview of the Following Chapters

The following chapters will be organized in the following manner: Discussion will begin with a review of literature, followed by a description of the practice-based research, outcome and analysis of intervention, and concluded with a discussion on how the findings can be used to enhance social work practice.

CHAPTER TWO

REVIEW OF LITERATURE

The literature review will provide a clear understanding of the nature of alcoholism, the definition, etiology, and consequences of alcoholism, the effectiveness of psychoeducational group intervention, and the theoretical framework which guides this research. The following areas will be addressed by the researcher: 1) alcoholism overview; 2) psychoeducational groups as the intervention; and 3) theoretical framework.

Alcoholism Overview

In discussing the topic of this research, the first question that must be answered is, "What is alcoholism?" Fisher and Harrison (1997) in *Substance Abuse: Information for School Counselors, Social Workers, Therapists, and Counselors* define alcoholism as an "addiction to a specific drug: alcohol" (p. 15). According to these authors, addiction occurs when an individual has a compulsion to use alcohol regardless of adverse or negative consequences (Fisher and Harrison, 1997). Addiction is characterized by both psychological and physical dependence. Psychological

dependence is the need to use alcohol, to think, feel, or function normally (Fisher and Harrison, 1997).

The DSM-IV (1994) diagnoses of alcohol dependence requires that at least three of the following seven criteria occur at any time in the same 12-month period:

1. tolerance: refers to the requirement for increasing doses or quantities of alcohol to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount of alcohol;
2. withdrawal: refers to those symptoms experienced when no alcohol is consumed, or a need to take alcohol or closely related substance to relieve or avoid withdrawal symptoms;
3. alcohol often taken in large amounts or over a longer period of time than was intended;
4. a persistent desire or unsuccessful effort to cut down or control alcohol use;
5. a great deal of time spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects;
6. important social, occupational, or recreational activities given up or reduced because of alcohol abuse; and

7. continued alcohol use despite knowledge of having a persistent or recurrent physical or psychological problem that was likely to have been caused or exacerbated by alcohol.

Etiology of Alcoholism

There is no single theory to explain the etiology of alcoholism, but several explanations have been suggested (Anderson, 1995). These include moral, sociocultural, psychological, biological, and multivariate models of addiction.

Moral Model

The moral model explains addiction as a consequence of personal choice (Fisher and Harrison, 1997). According to Anderson (1995), this view, based on Christian morality, assumes that the person suffering with alcoholism is defective in moral character and lacks the strength of will to resist temptation. From this perspective, individuals are perceived as making decisions to use alcohol in an unhealthy fashion and as being capable of making other choices (Fisher and Harrison, 1997).

Sociocultural and Psychological Models

While the moral model explains addiction as a personal choice resulting from spiritual or character deficiencies, the sociocultural and psychological models of addiction focus on factors that are external to the individual (Fisher

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and Harrison, 1997). These can include cultural, religious, family, and peer variables or psychological factors.

Sociocultural

Sociocultural theorists emphasize the role that societies play in individuals' drinking patterns. They note that societies vary in the ways they encourage or regulate the use of alcohol. For example, Stanton Peele (1989), in his book, *Diseasing of America: Addiction Treatment Out of Control*, points to the low rate of alcoholism among Chinese and Jewish populations. Peele provides a cultural explanation for this since these populations do not disapprove of the use of alcohol, but do disapprove of excessive drinking; particularly if it leads to problematic behavior. The author also suggests that the cultural acceptance of heavy drinking has been believed to account for the high rates of alcoholism among certain groups, such as Irish Americans (Peele, 1989).

Vega et al. (1993) suggest that American culture has fostered the use of alcohol as a social stimulator and a way to reduce tension. Society appears to reinforce effects of social drinking and advertises it as a mechanism for "gaiety and pleasant" social interaction (Vega, et al., 1993). Anderson (1995) states that "sociological theory is one of the least developed areas in the field of alcoholism, perhaps because of the difficulty in separating sociocultural variables from constitutional ones" (p. 205).

Psychological

Psychological theories assume that there is a certain type of personality or character that predisposes a person to use alcohol as their way of coping with stress (Hartford and Parker, 1994). This is commonly referred to as the "alcoholic personality" (Fisher and Harrison, 1997). Researchers have found that alcoholics tend to be emotionally immature, dependent, have grandiose tendencies, require an inordinate amount of praise and appreciation, react to failure with marked feelings of hurt and inferiority, have low frustration and tolerance, highly impulsive and aggressive, and feel inadequate and unsure of their abilities to fulfill expected male or female roles (Carson, et al., 1998).

Recent research has also focused on the relationship between alcoholism and other disorders, such as antisocial personality, depression, and schizophrenia (Carson, et al., 1998). Hartford and Parker (1994) report that the relationship between alcoholism and antisocial personality is strong, but it is not clear which disorder causes which. However, the authors do report that high rates of substance abuse are found among people with antisocial personalities. Both antisocial personality and depression are most frequently linked to alcoholism. Seventy-five to eighty percent of the research done in this area reports an association between the two (1994).

Buckley et al. (1994) have found links between alcoholism and schizophrenia, borderline personality, and anxiety disorders. Although research suggests that there is a relationship between the disorders, this does not suggest that disorders such as depression cause alcoholism. Carson et al. (1998) state, "an alcoholic's personality may be as much a result as a cause of his or her dependence on alcohol -- for example, the excessive use of alcohol may lead to depression, or a depressed person may turn to the excessive use of alcohol, or both" (p. 366).

Psychological theorists also postulate that early childhood experiences are associated with alcoholism. Vega et al. (1993) attributes alcoholism to failure in parental guidance. The authors emphasize the importance of stable family relationships and parental guidance in the development of children. The experiences and lessons children learn from important figures, such as mother and father, have a significant impact on their adult lives (Vega, et al., 1993).

The authors suggest that children exposed to negative models and/or experiences often stumble on the steps they must take in life. Formative experiences directly influence an individual's decision to engage in maladaptive behaviors, such as excessive drinking (Vega, et al., 1993).

Chassin (1993), in a study in which he evaluated the effect of negative socialization factors on alcohol use,

found that parents who abused alcohol resulted in their children also abusing alcohol. The author also reported that parenting skills and behavior were highly associated with excessive drinking. Alcoholic parents were less likely to monitor their child's activities, which resulted in them affiliating with peers who drank alcohol and used drugs (Chassin, 1993).

Psychological theorists assume that addictive behaviors, such as alcoholism, consist of overlearned maladaptive habit patterns usually followed by some form of immediate gratification (Anderson, 1995). According to this theory, alcohol is a mechanism by which individuals prevent themselves from feeling tension in their lives. Cooper (1994) suggests that alcoholism is a result of an individual's inability to deal with stress and tension. In response they utilize alcohol as a reinforcement. The author describes the typical alcoholic as "discontented with his or her life and unable to tolerate tension and stress" (p. 367). The alcoholic decides consciously or unconsciously to consume alcohol to produce affective changes, such as mood-altering effects (Cooper, 1994).

According to Filmore et al. (1994), excessive drinking often begins during crisis periods in marital and other intimate relationships. In fact, alcoholism is one of the most frequent causes of divorce in the United States (Filmore, et al., 1994). Alcoholism is also a factor in

financial and sexual problems in marriages (Filmore, et al., 1994). Filmore et al. (1994) suggest that when the alcoholic's interpersonal relationships begin to deteriorate, the stress presented results in increased substance abuse problems. The authors also found other relationships, such has father's alcoholism, lax maternal supervision, no attachment to father, and no family cohesiveness to be significant causes of alcoholism (Filmore, et al., 1994).

Biological

Genetic theorists of alcoholism assume that alcoholics are constitutionally predisposed or genetically vulnerable to develop a dependency on alcohol (Anderson, 1995). Kendler et al. (1992) found that genetics accounted for 50 to 60 percent of a woman's tendency to develop alcoholism. Bohman et al. (1981) found a threefold incidence of alcoholism among adopted-away daughters of alcoholic biological mothers, regardless of the presence or absence of alcoholism in the birth father or adoptive parents. Murray and Stabenau (1982) found that monozygotic twins have a higher concordance rate for alcoholism than do dizygotic twins. Goodwin (1979) found that the incidence of alcoholism among sons of alcoholics was four times greater than that among a control group of sons of nonalcoholics, whether the sons were raised by their own alcoholic parents or by nonalcoholic foster parents. Cloninger (1981), in a

study of children of alcoholics, reported strong evidence for the inheritance of alcoholism. He found that, for males, having one alcoholic parent increased the rate for alcoholism from 11.4 percent to 29.5 percent, and having two alcoholic parents increased the rate to 41.2 percent. For females with no alcoholic parents, the rate was 5.0 percent, while the rate for those with one alcoholic parent was 9.5 percent, and for those with two alcoholic parents, it was 25.0 percent.

According to Crabbe and Goldman (1992) research has proven that whether a person becomes alcoholic is dependent on the interaction of multiple "vulnerability" genes as well as environmental conditions that decrease or increase the probability of becoming an alcoholic. Anderson (1995) states, "although genetic knowledge will help identify individuals who are biologically at risk, the ultimate etiological model must take into account both genetic vulnerability and environmental reactivity" (p. 205).

Multivariate Model

The multivariate causal model views alcoholism as the final product of the interaction of a number of complex variables, including biological, psychological, and sociological. As emphasized by Fisher and Harrison (1997), people progress to abuse and addiction for a lot of different reasons. It is possible that progression in some people is due to a genetic predisposition. It is also

plausible that personality characteristics, physical or emotional pain, and/or environmental circumstances may explain problematic use of alcohol. Anderson (1995) suggests that this mode appears to be the most appropriate provided theoretical hypotheses on the etiology of alcoholism, provided others have not demonstrated an unequivocal, single cause of alcoholism.

Summary of Etiology of Alcoholism

Several theories have been proposed to explain the etiology of alcoholism, but as emphasized there appears to be no single cause. Zastrow and Ashman, in *Understanding Human Behavior and the Social Environment* (1994), state that, "social workers should not focus on a problem involved in only one system (that is, biological, psychological, or social) and ignore how other systems are affected" (p. 200). Their reasoning for this is that alcoholics' drinking results in all these systems impacting each other. Biologically, the alcoholic will lose weight and experience other physical problems, such as seizures and liver disorders. The alcoholics' physical health will in turn affect their psychological health in the sense that they become depressed, suicidal, and overall unhappy with themselves. Consequently, the alcoholics' psychological state affects their interactions with family, friends, co-workers, etc., to the point where they begin to avoid him.

It is important that social workers analyze all the systems when assessing alcoholic clients. Social workers must not assume that all alcoholics are biologically predisposed or psychologically handicapped. As emphasized earlier, any one or a combination of factors may explain problematic use of alcohol. Furthermore, regardless of how the alcoholism originated, all systems are affected in one way or another.

Consequences of Alcoholism

Whatever the cause of alcoholism may be, there is no dispute among researchers that it can have serious physical, emotional, and financial consequences (Anderson, 1995). According to Anderson, long term use of substantial amounts of alcohol can result in diarrhea, gastritis, pancreatitis, fatty liver, alcoholic hepatitis, and cirrhosis (1995). Excessive drinking is also related to increased risk of cancer of the mouth, tongue, pharynx, esophagus, stomach, colon, liver, and pancreas. Alcoholics generally develop degenerative heart disease, nutritional deficiencies, and acute and chronic brain damage. Alcoholic women often suffer from infertility and a number of gynecological problems. Alcoholic intake during pregnancy can result in harm to the fetus ranging from mild to physical and behavioral deficits to fetal alcohol syndrome.

The National Institute on Alcohol Abuse and Alcoholism (1992) reported a relationship between alcohol and HIV/AIDS.

Alcohol has been found to impair the ability of white blood cells to defend against HIV. They also reported that people are more likely to engage in risky sexual behaviors when drinking, because of its unbridling effects.

Lowenfels and Miller (1984) reported alcohol as a major cause of mortality and morbidity in the United States. A majority of traffic fatalities, fires and burns, hypothermia cases, falls, and homicides are associated with alcoholism. Alcohol is also associated with at least 20 percent of completed suicides.

Alcoholism also presents negative emotional effects on the alcoholic's children and family. According to Werner (1986), between six million and twelve million children live in households with at least one alcoholic parent. Despite the fact that many offspring of alcoholics do function well and do not develop serious problems, they are still at risk for alcoholism and other cognitive, emotional, and behavioral difficulties. Bennett et al. (1988) reported that children from alcoholic families generally have lower IQ, verbal, and reading scores. They also reported that these children have higher levels of depression and anxiety than children from non-alcoholic families. They are also more frequently diagnosed with having a conduct disorder.

Clair and Genest (1986), in a study in which they compared the family interactions of non-alcoholic to alcoholic families, found that alcoholic families tend to

have lower levels of family cohesion, expressiveness, independence, intellectual orientation, and higher levels of conflict.

According to Rice et al. (1991), alcoholism costs society billions of dollars each year. These costs consist primarily of the medical treatment provided as a result of excessive drinking. Other costs are associated with lost productivity, losses to society from premature deaths, treatment of fetal alcohol syndrome, criminal justice and social welfare administration, and property losses from motor vehicle crashes and fires.

Psychoeducational Group Intervention

According to Brennan (1995), an increasingly popular and important source in treating alcoholics are psychoeducational groups. Davis et al. (1990) define psychoeducation as the "process of disseminating information about the nature of a specific disorder for the purpose of fostering attitudinal and behavioral change in the client" (p. 882). The process is used by the practitioner to summarize relevant scientific information about a disorder and to address questions the client may have such as, "Why did I develop this problem? What can I do to get better?"

Psychoeducational groups focus on educating members and providing emotional support. They function to help alcoholics acquire the necessary knowledge to maintain or improve their physical and mental health. Brennan (1995)

suggests that alcoholics must learn that something is wrong with their way of life, what that something is, and how they can change it. Educational groups can serve to acquaint the alcoholic with the nature and management of his disorder, including his social and vocational problems. The groups can also serve to orient them to the facilities in the community and its change agencies and to the respective roles of patient and change-agent in the treatment process.

Psychoeducational groups provide alcoholics with information on the signs and symptoms of addiction, pharmacology and the effects of alcohol and other drugs, causes (biological, psychological, and social factors), physical sequelae, and behavioral changes that strengthen one's recovery from addiction. The groups also provide information on family issues in alcohol and how to address them, and on the social, medical, and psychological consequences of alcohol. These didactic activities are usually centered around a topic and utilize lectures, films, videotapes, displays, guest speakers, textbooks, and homework assignments. They are generally followed by a discussion period that not only clarifies factual issues but considers misconceptions and emotional reactions people have about themselves and their problem.

Miller and Hester (1995) discuss the rationale for the use of education in the treatment of alcohol:

> "U.S. alcohol treatment often includes a series of lectures and films...Implicit in such strategies is the assumption that alcohol problems evolve from deficient knowledge from a lack of information. When armed with correct and up-to-date knowledge, individuals presumably will be less likely to use alcohol in a hazardous fashion and to suffer the consequences" (p. 139).

The authors conducted a study on the knowledge base of alcoholics and found that most had little or no knowledge of the nature of the disorder. Many alcoholics are cognitively misinformed about the medical, psychological, and social issues of alcoholism, and educational groups have been found useful in altering these misconceptions.

Psychoeducational groups have become an important component of substance abuse treatment. Most programs specifically focus on treating either the emotional or physical aspects of the disorder. However, effective treatment for alcohol must emphasize the relationship between both aspects of the disorder. With the use of psychoeducational group techniques, many alcoholics often recover because of an improved understanding of complications and factors perpetuating the disorder.

Theoretical Framework

The theory guiding psychoeducational group intervention is the Cognitive Theory. The cognitive theory suggests that

involvement in self-defeating behaviors, such as alcoholism, can be reduced by modifying the faulty or erroneous thinking and maladaptive beliefs that underlie these behaviors (Beck, 1976). Beck, in *Cognitive Therapy and the Emotional Disorders*, states, "In the broadest sense, cognitive therapy consists of all the approaches that alleviate psychological distress through the medium of correcting faulty conceptions and self-signals" (p. 214).

The cognitive approach helps individuals to come to grips with the problems leading to emotional distress and to gain a broader perspective on their reliance for alcohol for pleasure and/or relief from discomfort. According to Patterson (1986), cognitive therapy focuses on helping patients overcome "blind spots, blurred perceptions, self-deceptions, and incorrect judgements" (p. 38). Since the behaviors or emotional reactions that bring the patient to treatment are the results of incorrect thinking, they are alleviated when the thinking is corrected (Patterson, 1986).

In addition to assisting individuals to come to grips with their problems, cognitive strategies help to reduce their urges and, at the same time, establish a stronger system of internal control (Beck, et al., 1993). Furthermore, cognitive therapy can help patients to combat their depression, anxiety, anger, or some other factor which frequently perpetuates addictive behaviors (Beck, et al., 1993). "A major thrust of cognitive therapy of alcoholism

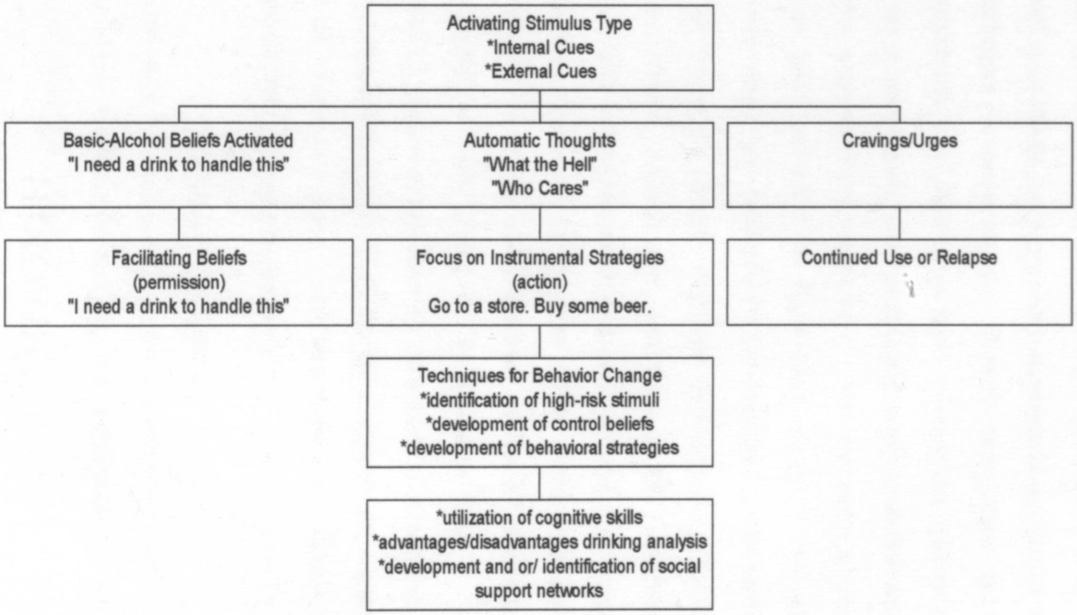
is to help the individual in two ways: (1) to reduce the intensity and frequency of the urges by undermining the underlying beliefs; and (2) to introduce the patient to specific techniques for controlling or managing their urges" (Beck, et al., 1993, p. 28).

Cognitive therapy is carried out several ways. The therapist helps the patient to explore the chain of events leading to alcohol use and then to explore the patient's basic beliefs about the value of alcohol. At the same time, the therapist works with the patient to help them to become able to evaluate and consider the ways in which faulty thinking produces stress and distress. Therapists help patients to modify their thinking so that they can gain a better grasp of their realistic problems and can disregard pseudo-problems derived from their faulty thinking. Also, patients are trained to build up a system of controls to utilize when confronted with strong urges (Beck, et al., 1993).

According to Zarb (1992), one of the major objectives of cognitive therapy is to help clients gain a new perspective on their problems. The therapist will be providing clients with new opportunities and enable them to work through their problems. Clients are taught how their cognition can help explain the etiology and maintenance of their maladaptive behaviors. According to Beck et al. (1993), at the core of the problem of the addicted

individual is a set of addictive beliefs which appear to derive from core beliefs, such as "I am helpless," "I am unlovable," or "I am vulnerable." It is these core beliefs that interact with life stressors to produce excessive anxiety, dysphoria, and anger. The authors note that these stressful situations do not directly cause cravings for the substance, but they do activate the substance-related beliefs that lead to the craving. Individuals who tend to believe that they cannot tolerate anxiety, frustration, and other uncomfortable feelings begin to build up expectations that can only relieve these unwanted feelings through drinking. Thus, when an unpleasant effect occurs, the individual naturally attempts to neutralize it by drinking alcohol. The ultimate goal of cognitive therapy is to correct faulty cognitions or erroneous thinking, which will produce desired changes in behavior. A cognitive model of substance abuse is depicted in figure 1.

Figure 1. A Cognitive Model of Substance Abuse



Summary of Proposed Study

Although psychoeducational group intervention is a commonly used strategy in treating alcoholism, it is not without criticism. Lewis et al. (1994) criticize this treatment approach for assuming that educating clients about alcoholism is a necessary and possibly even sufficient mechanism for engendering sobriety. The authors state that, "one would be hard pressed to find real support for the generalization that the provision of factual information can be counted on to bring about desired changes in attitude or behavior" (p. 300). Fisher and Harrison (1997) further criticize the use of psychoeducational groups for presenting information to clients in treatment with little or no regard for the learning capacity or learning style of the client.

The purpose of this study is to measure the effectiveness of psychoeducational groups in treating alcoholism. The researcher monitored changes in alcohol involvement of a middle-aged, African American woman engaged in psychoeducational group treatment.

Research Question

Is psychoeducational group intervention effective in educating clients about alcoholism and ultimately reducing their level of alcohol intake?

Treatment Hypothesis

As a result of psychoeducational and cognitive therapy, the client will reduce her level of alcohol intake. It is hypothesized that when one is more educated about alcoholism and how the addictive behavior began, their level of alcohol involvement will decrease.

CHAPTER THREE

METHODOLOGY

The methodology section is organized in the following manner: (1) Research Design; (2) Instrument; (3) Setting; (4) Treatment Hypothesis; (5) Case Information; and (6) Intervention and Implementation.

Research Design

The single system A-B-C research design was used in this study. Bloom et al. (1999) describes the use of single system designs by social workers as a way of monitoring and evaluating clients' outcome in the intervention with which they address the target problem.

The researcher obtained the client's level of alcohol involvement through administering a self-anchored rating scale during baseline, intervention, and follow-up phases. A self-report was needed, because the problem involved private behaviors of the client. Information about the target problem was most directly available to the client.

The Hudson's Index of Alcohol Involvement was utilized by the researcher in making an assessment of the subject's level of alcohol involvement. It is a standardized scale specifically developed to measure a subject's use of

alcohol. The scores of the scale range from 1 = never, 2 = very rarely, 3 = a little of the time, 4 = some of the time, 5 = a good part of the time, 6 = most of the time, and 7 = always.

The researcher administered the Hudson's scale to the subject first during the baseline phase, prior to any intervention. Baseline data were collected over the course of three weeks. This time frame was chosen because the patient remained in the hospital for this length of time. The same scale was further administered to the subject during the intervention phase, based on six psycho-educational group sessions. The researcher also administered the scale to the subject during the follow-up phase to ensure that the desired goals have been maintained outside of treatment. Follow-up data were collected two weeks after intervention has been terminated.

According to Bloom et al. (1999), the heart of single-system designs is the repeated measurement of the target for intervention. In order for the study to be effective, the researcher had to repeatedly measure the client's alcohol involvement, because without these measurements there can be no single-system designs (Bloom, et al., 1999). Bloom et al. also emphasized the standardization of measurement procedures. Standardization refers to the "uniformity of procedures when administering and scoring a measure, and implies the availability of existing data concerning the

validity and reliability of the measure" (Bloom, et al., 1999, p. 200). The researcher of this study administered the same scale under the same conditions from baseline to follow-up phases, to accurately measure the subject's alcohol involvement.

Instrument

Hudson's Index of Alcohol Involvement was the instrument used to measure the subject's level of alcohol involvement. This instrument is a standardized questionnaire designed specifically for single-system evaluation to monitor and evaluate the magnitude of the client's drinking problem through periodic administration of the same questionnaire to the client (Bloom, et al., 1999). The scores of the scale range from 1 = never, 2 = very rarely, 3 = a little of the time, 4 = some of the time, 5 = a good part of the time, 6 = most of the time, and 7 = always.

The Hudson Index of Alcohol Involvement has been proven feasible for use with single-system designs (Bloom, et al., 1999). The scale has internal consistency of .90 or better, which is considered very high. The scale also is reported as having a high validity, which means that the scale measures what it intended to measure. Furthermore, according to Bloom et al. (1999), the instrument has the ability to discriminate between people known or admitting to have alcohol problems, and people who claim or are known not have alcohol problems. Other benefits of the scale include:

the scale is short (25 questions), easy to administer, easy to score and interpret, and easy for patient's to complete.

Despite the strengths of self-report questionnaires, there are some limitations in using this method of measurement. Limitations occur when the client responds to each item on the questionnaire in the same or patterned way, referred to as response bias. Self-report questionnaires are also subject to social desirability response, which occurs when the client's responses to some items are based more on what the client thinks he or she should say than on what is actually occurring. To minimize response bias and social desirability response, the scale contains some "reverse scored" items, identified at the bottom of the scale.

The procedure for scoring the instrument is as follows:

1. All identified scores are reversed;
2. All scores are added together;
3. Subtract the number of items properly completed;
4. Multiply this number by 100;
5. Divide this number by the number of items properly completed; and
6. This number is then multiplied by the largest possible value for an item response minus 1.

The lowest possible score that can be made is 0 and the highest is 100. The higher the score, the greater the magnitude of the client's drinking problem. The scale has

clinical cutting score of approximately 30. Clients scoring over 30 are said to have a drinking problem which prevents them from functioning in the environment. According to Bloom et al. (1999), the cutting score provides a "rough diagnostic" indicator and useful standard against which the practitioner can determine the success of their intervention.

The authors suggest that researchers consider a range of values from 25 to 35 as a gray area that does not validate the possible presence or absence of a drinking problem. This gray area is based on the fact that the standard error of measurement for this particular scale is 5. Therefore a score of 24 doesn't absolutely indicate the absence of a problem, and a score of 36 doesn't absolutely indicate the presence of a problem. The main point is that higher scores should be seen as requiring some attention or intervention, with the goal being to reduce those scores to at least below 30.

Setting

The setting for the study was the Social Services Department at Grady Health System in Atlanta, Georgia. The patient used in the study was a patient in the hospital prior to beginning intervention. The groups took place on Tuesday mornings from 8:30 a.m. to 11:30 a.m. The meeting place was in a private room located in the Social Services Department. Before the study began, the subject signed a

consent form, specifically used in evaluation with single-system designs. Consent in this context is for practice to proceed and includes consent for evaluation.

Treatment Hypothesis

As a result of psychoeducational group therapy, the client will reduce her level of alcohol intake. It is hypothesized that when one is more educated about alcoholism and how the addictive behavior began, their level of alcohol intake will decrease.

Case Information

The National Association of Social Work (NASW) Code of Ethics (1997), Rule 1, Section 1.07 sets the guidelines for respecting the privacy and confidentiality of the clients. Social workers should respect clients' right to privacy and protect the confidentiality of clients. To protect the client's anonymity, a fictitious name will be used when referring to the client used in this research. She will be referred to as Samantha Scott. Samantha Scott is a separated, 50 year old, African American female. The problem is that Mrs. Scott has consumed alcohol on a daily basis for the past twenty years. Mrs. Scott has no stable work history. Her most recent employment was at Turner Field, where she worked as a security officer. She lives alone in a small apartment in College Park, Georgia. Mrs. Scott decided to attend the Alcohol and Drug Abuse

Prevention Program at Grady Memorial Hospital after sustaining a laceration to her right arm, sprained chest muscles, and a fractured bone in her back, resulting from a fall. One morning, while attempting to catch the train to work, she had a seizure, causing her to get trapped in a MARTA escalator. She admitted to having five beers that morning. The inpatient social worker referred her to the Alcohol/Drug Abuse Prevention Program at Grady Hospital. Mrs. Scott's son supports her by paying her rent, buying food, etc.

Mrs. Scott has been detoxified from alcohol at least two times in 20 years. She had never attended outpatient treatment. The client dates the onset of her drinking to twenty years earlier, when her husband left her. She also stated that her mother, now deceased, was an alcoholic. Mrs. Scott has suffered a multitude of problems over the years as a result of her drinking. She has not been able to sustain a job, has loss contact with friends, has a poor relationship with her son, and often has seizures. She stated that when she does not drink, she experiences the shakes.

A review of systems uncovered the following information: she has physical problems, resulting from alcohol use; she is slightly depressed, but manifests no symptoms of a major mental disorder; she tends to handle problems rigidly and reactively; she is not introspective,

responding, "That's the way things are" and "I guess I'm an alcoholic"; she has no boyfriend or contact with estranged husband; she has one son; and her leisure time is spent watching television, sleeping, and drinking alcohol.

Intervention Strategy and Implementation

The target problem or dependent variable is alcoholism. Mrs. Scott, the client, is an alcoholic. The goal of intervention is that the client will remain abstinent from alcohol or at least reduce her level of alcohol intake. The objectives include:

- Mrs. Scott will attend one psychoeducational group per week
- Participate in brief individual counseling sessions with the clinician
- Keep a daily log of any relapses and what was occurring at the time

The client carried out the goal and objectives in attempting to reduce her level of alcohol intake. The researcher facilitated this process by providing the client with direction and feedback. The researcher acted as facilitator throughout the entire intervention process, while the client worked to achieve their goal and objectives.

Mrs. Scott attended six, three-hour group sessions on Tuesdays. Afterwards, the client briefly met with the

researcher to discuss any issues that arose during the group. This process remained the same throughout the intervention period of six weeks. The client met with the researcher one month after termination of intervention to measure any changes in her alcohol intake. The brief individual meetings were not the primary source of intervention, but utilized to develop issues arising in the groups and to measure the effectiveness of intervention. The purpose of the group is to provide members with a better understanding of the complications and risk factors associated with alcoholism. The primary goal of the group was to provide members with the necessary knowledge and skills to enable them to eliminate or at least reduce their level of alcohol intake. The objectives designed to meet this goal included:

- group facilitator assisted members in identifying high risk stimuli or the activating stimulus/situation which perpetuates the disorder. These may be internal cues, such as depression, anxiety, boredom, isolation, etc., or they may be external cues, such as gathering of friends drinking;
- group facilitator helped members develop control beliefs that reduce vulnerability to lapses and relapses;
- group facilitator helped the members develop behavioral strategies;

- group facilitator assisted members in becoming able to utilize cognitive skills;
- members established a list of the advantages and disadvantages of alcoholism; and
- group facilitator assisted members in the development and/or identification of social support networks.

Mrs. Scott attended six group meetings, each of which covered one of the above topics. Mrs. Scott reported that upon completing the sessions, she felt as though she had more control over her drinking. Before attending the sessions, she stated that she believed there was nothing she could do (she was just going to be an alcoholic). As a result of the psychoeducational groups, she was able to identify some factors (that is, biological, psychological. and sociological) that perpetuated the disorder. She was able to identify situations that triggered her drinking, such as family gatherings, job parties, anxiety, stress, crises, and major transitions in life. Knowing these things made Mrs. Scott feel as though she had power over the disorder. Once Mrs. Scott became aware of the many factors causing the alcoholism, she was able to develop control beliefs that reduce vulnerability to lapses and relapses, and begin to utilize cognitive skills.

Mrs. Scott also stated that the support from the group itself, increased her confidence level and self-esteem. She did not feel alone or ashamed to admit her drinking. By

hearing other members share their experiences with alcoholism, she realized that many others were dealing with the same problems as she.

CHAPTER FOUR

PRESENTATION OF FINDINGS

The graphs presented on the following pages present the subject's scores on the Hudson's Index of Alcohol Involvement in the baseline, intervention, and follow-up phases. The scores in the baseline phase illustrate the subject's level of alcohol involvement prior to any intervention or treatment. The scores in the intervention phase demonstrate the effectiveness of psychoeducational group intervention in treating alcoholism. Lastly, the score in the follow-up phase validate the effectiveness of this method of treatment, once it was completed.

Figure 2 represents the baseline scores. The baseline was established by administering the scale over a three week period. The scale was administered to the subject once a week. As shown in figure 2, the baseline score was 100. A score of 100 indicates that the subject does have a severe drinking problem. This is the highest possible score that can be made.

FIGURE 2. PATIENT'S ALCOHOL INVOLVEMENT IN BASELINE PHASE

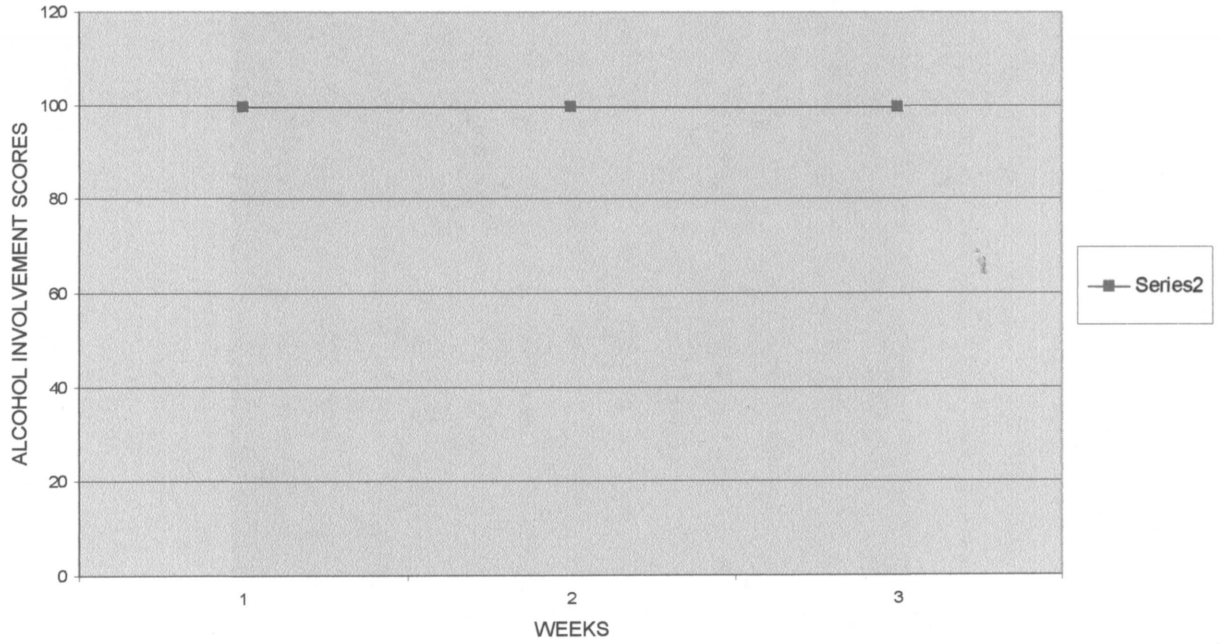


Figure 3 illustrates the subject's level of alcohol involvement in the intervention phase. As shown in Figure 3, there was a dramatic change in the subject's drinking. In the first week of intervention, the client's level of alcohol involvement did not change. The score remained at 100. This was probably due to the fact that intervention had just begun. In weeks two and three, the score decreased to 67. However, a score of 67 still indicates a drinking problem. In week four, the subject's score reduced to 33, which is below the clinical cutoff point. However, 33 is in the gray area and, as it was mentioned in chapter four, the scale contains a gray area consisting of scores between 25 and 35. Scores that fall in this area do not validate the possible presence or absence of a drinking problem. In weeks five and six, the subject scored 17. The subject reached the goal of reducing her level of alcohol intake. A score of 17 is far below the clinical cutoff point. Thus, it can safely be determined that the subject's alcohol usage was now very rare and did not have an impairing effect on her ability to function within the environment.

FIGURE 3. PATIENT'S ALCOHOL INVOLVEMENT IN INTERVENTION PHASE

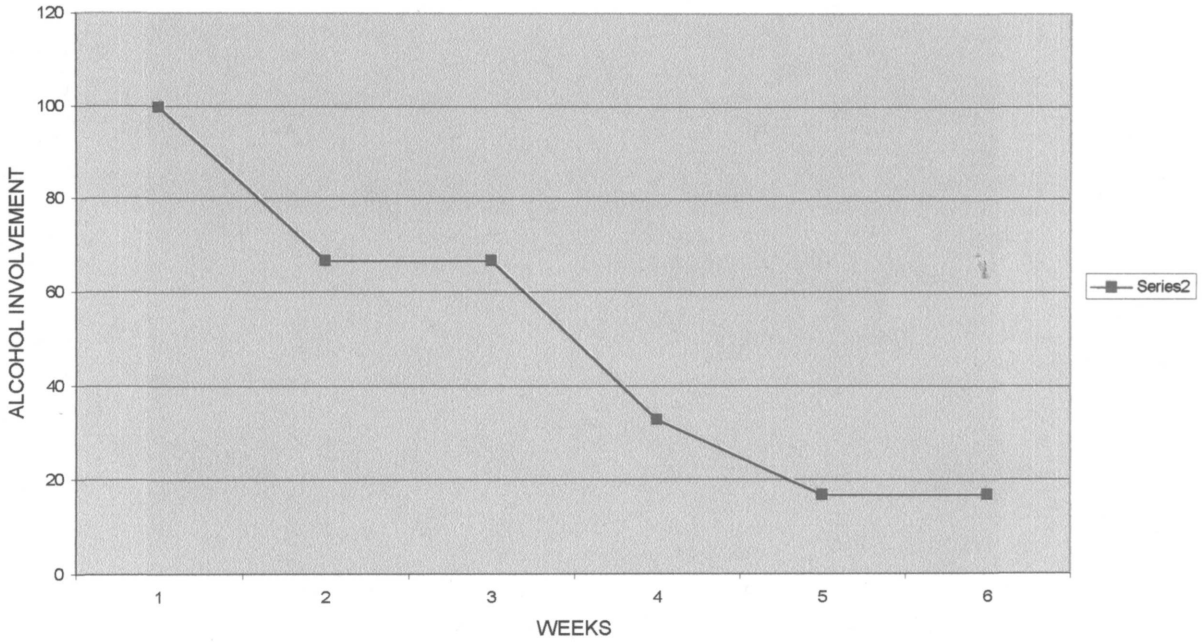


FIGURE 4. PATIENT'S ALCOHOL INVOLVEMENT IN FOLLOW-UP PHASE

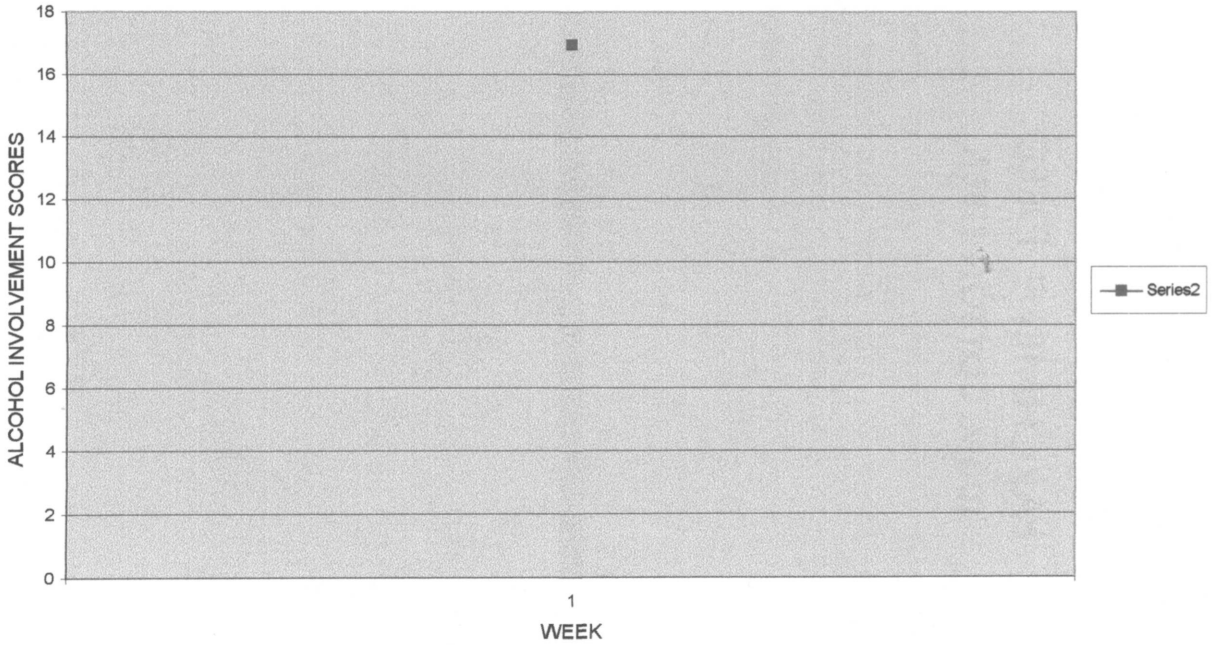
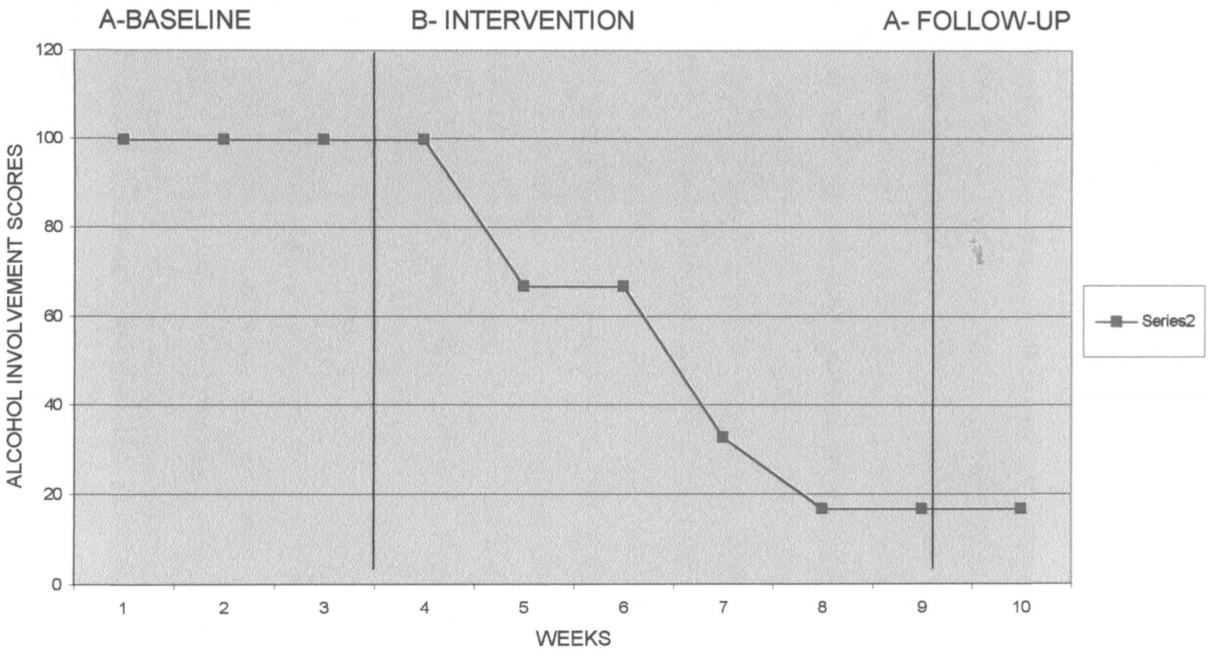


Figure 4 illustrates the subject's level of alcohol involvement after termination of intervention. The subject was administered the same scale two weeks after termination. The subject's score remained at 17. There was no increase or decrease in her alcohol usage.

Figure 5 provides a total picture of the entire treatment process, from baseline, intervention, and follow-up phases. As shown, there was a strong decrease in the subject's alcohol involvement, resulting from psycho-educational group intervention.

FIGURE 5. PATIENT'S ALCOHOL INVOLVEMENT IN BASELINE, INTERVENTION, AND FOLLOW-UP PHASES



CHAPTER FIVE

CONCLUSIONS

The goal of the study was to reduce the subject's level of alcohol involvement through the use of cognitive therapy and psychoeducational group intervention. The results of the study demonstrated that the use of psychoeducational group intervention was effective in reducing the subject's level of alcohol involvement. The results prove that education is an essential component in the treatment of alcoholism. It is through education that the client became acquainted with the nature and management of her disorder. The client began to understand why and how she developed the disorder and what she could do to get better. Education helped to modify the faulty or erroneous beliefs that underlie alcoholism, such as "I need a drink to handle this" or "I am unlovable." The client came to grips with the problems leading to emotional distress and gained a broader perspective on her reliance for alcohol for pleasure and/or relief from discomfort. Once the client became aware of those blind spots, blurred perceptions, self-deceptions, and incorrect judgements, the researcher was then able to help the client correct her thinking. The researcher also

assisted the client in building up a system of controls when confronted with strong urges.

Limitations of the Study

Although the intervention proved to be effective in treating alcoholism, only one subject was used in this study. The goal of single system designs is to measure the effectiveness of a specific intervention by continuously observing one client before, during, and after intervention. The results of the study allow the researcher to determine whether the intervention is effective or not. However, by using one subject, the generalizability of the effectiveness is limited.

Recommendations for Future Studies

For future studies on the effectiveness of psycho-educational groups in treating alcoholism, a larger, more diverse population should be used to test the effectiveness among different groups. In addition, future studies may want to include a secondary form of measurement to further validate the intervention's effectiveness. Lastly, future studies may want to incorporate continued follow-up. The program evaluated for this study is not designed to measure the progress or regress of patients once they have completed the program. To obtain a more accurate assessment of the effectiveness of psychoeducational groups, clients should be followed for several months after termination of

intervention. This will allow the researcher to determine if the client can apply the knowledge and skills acquired from the group when faced with real life situations over long periods of time.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

The occurrences of alcoholism and alcoholism related problems are increasing among the United States population. The National Institute on Alcohol Abuse and Alcoholism (NIAAA, 1990) reported that 11 million Americans suffer from alcoholism or alcohol dependence and 7 million from alcohol abuse. Given these statistics, social workers are very likely to encounter numerous clients suffering from alcoholism or alcohol abuse. Although alcoholism may not be the problem which the client is seeking treatment for, a psychosocial assessment of the client will probably reveal some alcohol involvement.

It is the obligation of the social profession to become more knowledgeable about the etiology of alcoholism, its affect on the environment, and the effectiveness of various treatment approaches. As it currently stands, social workers do not appear to be well represented in substance abuse treatment programs when considering the problems of the client populations and the program functions that need to be performed.

The Institute of Medicine (1990) has reported that future substance abuse treatment will emphasize the

development of a broader range of programs and services to meet the range of clients' needs with a concurrent emphasis on matching clients to treatment. Social work is the key profession to respond to these changes in the substance abuse field.

The use of psychoeducational group intervention has proven to be effective in this study. This method of treatment approach represents a shift from the traditional disease model of addiction, which views alcoholism as an incurable disease. Psychoeducational group intervention takes a more ecological approach in that it analyzes the biological, psychological, and sociological factors that may be causing the alcoholism. Psychoeducational group intervention also focuses on the client's strengths and assumes that all individuals are capable of change. This study has shown that through education and cognitive therapy, individuals can reduce their level of alcohol intake.

Social workers may want to consider using psychoeducational group intervention in working with alcoholic clients. Social workers should become familiar with the dynamics of this treatment approach as well as others. It is incumbent that workers begin to explore various treatment approaches and evaluate their effectiveness in practice.

Evaluation of practice demonstrates our accountability to ourselves, our clients, and our consumers. Use of

evaluation methods with numbers of clients can lead to new practice hypotheses that can further the knowledge base of the profession.

APPENDICES

APPENDIX A

CLIENT CONSENT FORM

Preamble: This statement of intent for services to be rendered to _____(client) by _____(practitioner) beginning on _____(date).

1. The following are targets to which we will devote our cooperative efforts: (state problems or objects as relevant)
   A. Problem:_____ Objective:_____
   B. Problem:_____ Objective:_____etc.

2. The overall goals of service are:
   A. _____ B._____etc.

3. The practitioner and client agree to work together exactly _____ weeks.

4. We (client and practitioner) have decided that _____ approach is most likely to be helpful with the least negative side effects.

5. In considering how to monitor ongoing events in this situation, and to evaluate the outcome, the client and practitioner agree that _____ is most likely to be helpful in understanding their changes in behavior.

6. In these evaluation methods, it is understood that:
   A. _____(client) will give
   B. _____(specified types of information such as measures used) to
   C. _____(practitioner) on
   D. _____(date information will be received) which will then be analyzed and interpreted by the practitioner and shared as appropriate with client and relevant others.

7. The costs or fees involved in this service are set by the agency. The total fees are as follows:_____

8. Several kinds of records will be kept:
   First, a service record in which the practitioner indicates summaries of client contacts.
   Second, agency records are kept related to fiscal matters for this case and the entire caseload of the agency.
   Third, information is kept monitoring the progress of the case, and whether or not case objectives are attained.

APPENDIX A

(continued)

9. Access to the records on this case will be restricted to:
   a. agency personnel (for case management/collective thinking, and for fiscal matters)
   b. research personnel (for collective analysis--no individual names will be identified)
   c. outside legal authorities (only when case records are subpoenaed)

10. Special requests regarding the practice and evaluation of this situation as made by the client, and agreed to by the practitioner:
   A. _____ B. _____ etc.

Client's signature_____

Practitioner's signature_____

Date_____

APPENDIX B

INDEX OF ALCOHOL INVOLVEMENT (IAI)

Name:_____Today's Date:_____

This questionnaire is designed to measure your use of alcohol. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows:

1 = Never
2 = Very rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = Always

1.___ When I have a drink with my friends, I usually drink more than they do.

2.___ My family and friends tell me I drink too much.

3.___ I feel that I drink too much alcohol.

4.___ After I've had one or two drinks, it is difficult for me to stop drinking.

5.___ When I am drinking, I have three or fewer drinks.

6.___ I feel guilty about what happened when I have been drinking.

7.___ When I go drinking, I get into fights.

8.___ My drinking causes problems with my family or friends.

9.___ My drinking causes problems with my work.

10.___ After I have been drinking, I cannot remember things that happened when I think about them the next day.

11.___ After I have been drinking, I get the shakes.

12.___ My friends think I have a drinking problem.

APPENDIX B

(continued)

13.___ I drink to calm my nerves or make me feel better.

14.___ I drink when I am alone.

15.___ I drink until I go to sleep or pass out.

16.___ My drinking interferes with obligations to my family or friends.

17.___ I have one or more drinks when things are not going well for me.

18.___ It is hard for me to stop drinking when I want to.

19.___ I have one or more drinks before noon.

20.___ My friends think my level of drinking is acceptable.

21.___ I get mean and angry when I drink.

22.___ My friends avoid me when I am drinking.

23.___ I avoid drinking to excess.

24.___ My personal life gets very troublesome when I drink.

25.___ I drink 3 to 4 times a week.

5, 20, 23

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